Nursing ethics

Summary Article: Ethical Issues in Nursing Practice
From The Penn Center Guide to Bioethics

Nursing is a discipline that is critical to the health and welfare of all nations and the backbone of any health care system. Without a sufficient supply of nurses to care for the public’s needs, the public’s health is at risk. Unfortunately, the United States is currently experiencing a nationwide nursing shortage and it is estimated that 500,000 additional nurses will be needed by the year 2025 (United Press International, 2008). This represents a potential public health crisis; at a time when we are facing an unprecedented nursing shortage and a need for qualified nurse providers, recruitment and retention efforts should focus on long-term solutions, not simply quick fixes. Regrettably, ethics dialogue is not generally part of this solution, as nurses leave the profession, in part, because of unresolved ethical issues. In the past, nurses were more subordinate than they are today, and changes in the profession continue to address the legitimate role of nursing in society.

In light of these changes, nurses still face ethical challenges that stem from their unique position in the health care system. Historical issues of subordination, limited autonomy, lack of respect, and perception of powerlessness continue to haunt the profession and create sources of frustration, distress, and dissatisfaction. Ultimately, many nurses leave their positions. Therefore, it is important to define and discuss the ethical issues that the nursing profession faces in order to improve not only recruitment and retention of nurses but also address patient-centered care, the overall public good, and the future of health care.

Defining the field of nursing ethics is germane to this process. What is nursing ethics and how is this field addressing ethical issues specific to nursing practice? Is it a separate and distinct field of scholarly inquiry, an amalgam of medical ethics and/or something subsumed under medicine’s umbrella? Importantly, how has this message been conveyed to relevant stakeholders to assist nurses within the health care system, if at all? The purpose of this chapter is to provide an overview of the ethical problems in nursing practice and to discuss some of the shared ethical issues that cut across various specialties. We will also discuss the term nursing ethics, its historical beginnings, and the importance of this field to the nursing profession, and we will suggest long-term solutions for key constituents, including administrators, policy makers, and the public at large.

HISTORICAL BACKGROUND

Nurses have encountered ethical problems in their clinical and professional practice since the early 19th century. In her Notes on Nursing, Florence Nightingale (1859) discusses the importance of ethical actions such as listening to patients, upholding confidentiality, and putting patients’ needs first. These acts of beneficent caring reflect early indicators of a nursing ethic or what might be considered essential ethical duties of the profession. In fact, Nightingale (1859) noted that nursing was a specialty and that the knowledge of nursing was essentially separate and distinct from that of medicine. And since 1900, not a single decade has passed without at least one publication on nursing ethics, with the earliest nursing text being published in 1886 (Jameton, 1984; Luckes, 1886). Additionally, although we believe that nursing ethics is a legitimate field of scientific inquiry, there continues to be no general consensus on whether it is distinct from other subdisciplines of applied ethics, such as medical ethics (Fry & Veatch, 2000; Volker, 2003).
Ethics courses were commonly included in nursing curriculum until World War II (Jameton, 1984). In the early 1900s, nursing ethics focused on nursing character and virtues, such as discipline, because professional behavior was perceived as part of moral character (Perry, 1906; Volbrecht, 2002). Loyalty, obedience, and nursing duties were major foci of nursing ethics during this time. The Nightingale pledge, first used in 1893, emphasized loyalty as a key virtue of the nurse and of nursing ethics (Winslow, 1984). This was further enforced in Aikens’s text (1916) on nursing ethics, a standard book for over 20 years (Winslow, 1984). Indeed, this sense of loyalty to physicians and others in authoritative positions precluded nurses from questioning the judgment or patient treatment prescriptions of other members of the health care team. To question a physician was to create doubts about his or her character, ultimately diminishing the confidence of the patient that was considered essential to illness management (Winslow, 1984). Of course, this behavior created difficult moral dilemmas for many nurses, which to some degree still exists today. Where the nursing profession's loyalty lies is an ethical question that even now creates conflict in the provision of patient care and has only intensified with increased autonomy within nursing, technological and genetic advancements, cost concerns, and an aging society.

As the mid-1900s approached and World War II started, nursing curriculum adopted courses in science and health care technology and omitted nursing ethics from the curriculum. At this time, the American Nurses Association (ANA) and the International Council of Nurses (ICN) adopted their codes of ethics (ANA, 1950; ICN, 1953). These codes of ethics outlined essential principles and duties of the profession and served as a guiding force for ethical conduct. Hospitals and other health care institutions also began adopting codes and regulations for nurses to follow rather than providing ethics training as part of their core educational requirements.

By the late 1900s, nurses rediscovered and refined their own ethics. In 1973, the ICN revised the beginning of their code of ethics from “The nurse is under an obligation to carry out the physician’s orders intelligently and loyally” (Code for Nurses, 1965) to “The nurse sustains a cooperative relationship with co-workers in nursing and other fields” (Code for Nurses, 1973). The ICN Code of Ethics for Nurses (ICN Code of Ethics for Nurses, 2006) now includes the statement, “The nurse’s primary professional responsibility is to people requiring nursing care,” emphasizing the nurse’s responsibility to the patient and human rights rather than duties and loyalty to physicians and others. These codes are not stagnant; they are frequently revisited and updated as issues arise within the profession and societal needs change.

Sara Fry, Anne Davis, Patricia Benner, and other early nursing ethics leaders set the stage for a fuller discussion of the ethical problems nurses encounter in their daily practice, and they are credited for their honest and candid portrayal of and dialogue on many sensitive ethical issues. With societal changes, nurses have gained greater independence and can fully participate in ethical decision-making related to patient care. As nurses have become more autonomous, however, the need for ethics education in nursing curriculums has resurfaced, and we believe that nursing ethics needs to be defined as a legitimate field of inquiry within academia.

Fry and Veatch (2000) agree that while nursing ethics falls under the umbrella of bioethics, it is not the same as medical ethics. While nursing and medicine face similar ethical issues, there are also distinct issues because the physician-patient relationship is inherently different from the nurse-patient relationship. Nevertheless, we need to identify what it is that makes nursing ethics unique. Is it the holistic and healing relationship that nurses have with patients? Is it the nature of the ethical issues that
arise or that are inherently imbedded within the practice? Is it the in-between role of nurses who must function between physicians, patients, and differing hierarchal positions within institutions (Bishop & Scudder, 2001; Engelhardt, 1985; Hamric, 2001; Volker, 2003)? Or maybe it is a combination of these and other criteria?

ETHICAL ISSUES IN NURSING PRACTICE

Nurses are confronted with complex ethical challenges on a daily basis. These present themselves in various manners in a myriad of nursing specialties. In his text on nursing ethics, Jameton (1984) first described three different types of moral problems in nursing: moral uncertainty, moral dilemma, and moral distress. Today, nurses experience all three types of moral problems with serious consequences for the profession and the health care needs of society. First, moral uncertainty exists when nurses do not know the ethically correct action in a given situation, and this may lead to silence “out of deference to the judgment of others, out of fear that their comments will be ignored, or out of uncertainty that what they might have to say is really not that important” (Bird, 1996, p. 1). Second, moral dilemmas occur in nursing when (two or more) competing morally correct courses of action can be equally justified (Beauchamp & Childress, 2001; Purtilo, 2005). In choosing one course of action over the other, the nurse is between a rock and a hard place that potentially threatens her integrity. The nurse chooses a morally correct action, but in doing so, a sense of wrongdoing by not choosing “the other thing that is also right” may arise (Purtilo, 2005, p. 39). Third, moral distress occurs when the agent knows the morally correct action but is precluded from taking it because of external constraints on his/her practice—organizational, legal, authoritative power, or simply time pressures. Here, a nurse might ask him/herself, Why am I continuing to participate in providing care that I believe is morally wrong and only creates more suffering? Moral distress, then, often leads to feelings of anger, frustration, and guilt, contributing to nurse burnout, turnover, and nurses leaving the profession (Corley, 1995; Corley, Elswick, Gorman, & Clor, 2001; Elpern, Covert, & Kleinpell, 2005; Kelly, 1998; Sundin-Huard & Fahy, 1999; Wilkinson, 1987/1988).

Each nursing specialty presents its own unique set of ethical issues for nurses, most likely because of the nature of the patients’ illnesses, social commitment to treatment, the technology, the organization, and the relationship of professionals delivering care (e.g., the relationship between nurses and their coworkers, physicians, other professionals; Redman & Fry, 2000). Research has highlighted these particular ethical problems in specialties such as community health, acute care and hospital-based care, mental health, critical care, home care, oncology, diabetes care, nephrology, rehabilitation, pediatric care, administration, and managed care. For example, critical care nurses are often confronted with conflicts related to prolonging a patient’s life without benefit while mental health nurses struggle with delivery of care to a patient against his/her will. Although these issues differ, basic ethical principles of “doing good,” “avoiding harm,” “respecting patient rights,” and “providing just care” are universal (see Table 13.1).

It is not unusual for nurses to struggle with balancing the benefits and burdens of patient care, including discontinuing or initiating treatments, particularly in terminally ill patients. Other particular concerns include respecting patient autonomy by respecting the right to refuse care, following or not following patients’ advance directives, issues of informed consent, administering life-prolonging aggressive therapies, and compromising professional and personal integrity.

While studies have shown that nurses experience unique issues within specialties, a few ethical issues
cut across nursing practice in general. These include: quality of care, adequacy of staffing and resource allocation, and autonomy. Frequently identified issues include informed consent, advance directives, restraint use, patient-provider relationship, use of aggressive therapies to prolong life, patient advocacy/protecting patient rights, providing high-risk care (risk to providers), and nurse-physician relationships (Butz, Redman, Fry, & Kolodner, 1998; Ferrell & Rivera, 1995; Killen, Fry, & Damrosch, 1996; Redman & Fry, 1996, 1998a, 1998b, 2000, 2003; Redman, Hill, & Fry, 1997; Severinsson & Hummelvoll, 2001; Ulrich, Soeken, & Miller, 2003). These day-to-day ethical challenges that nurses must grapple with receive little attention (Hamric, 2000). However, the individual and collective research results beg serious pragmatic and normative questions about what can and ought to be done that will make a difference for nurses.

Table 13.1 Ethical Issues in Nursing Practice Categorized by Guiding Ethical Principles and Values

<table>
<thead>
<tr>
<th>Beneficence</th>
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<tr>
<td>—Administering life-prolonging aggressive therapies.</td>
<td>—Balancing the risks and benefits to patients.</td>
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<tr>
<td>—Discontinuing or initiating treatments such as dialysis, particularly with regard to terminally ill patients.</td>
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<tr>
<td>—Undertreating pain.</td>
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<td>—Over- or undertreating patients.</td>
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<td>—Using or not using physical or chemical restraints.</td>
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<td>—Overriding patient care needs by business decisions.</td>
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<tr>
<td>—Staffing patterns that limit patient access to nursing care.</td>
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<tr>
<td>—Patient advocacy.</td>
<td></td>
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<tr>
<td>—Quality of medical care patients receive.</td>
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| Respect for persons                                                      |                                                                 |
|——Creating a good relationship with the patient.                         |                                                                 |
|——Respecting patients’ autonomy.                                         |                                                                 |
| Right to refuse treatment.                                               |                                                                 |
| Do not resuscitate orders.                                               |                                                                 |
| Following or not following advance directives.                           |                                                                 |
| Informed consent.                                                        |                                                                 |
| Respecting or not respecting informed consent for treatment.             |                                                                 |
| Deciding the ethically correct action for a patient.                    |                                                                 |
|——Respecting patients’ rights.                                           |                                                                 |
| Providing care against the patient’s will.                              |                                                                 |
| Patients’ rights.                                                        |                                                                 |
| Protecting the child’s rights.                                           |                                                                 |
| Protecting patient rights and human dignity.                             |                                                                 |

Note. Table is not exhaustive (Butz et al., 1998; Ferrell & Rivera, 1995; Killen et al., 1996; Redman & Fry, 1996, 1998a, 1998b, 2000, 2003; Redman, Hill, & Fry, 1997; Severinsson & Hummelvoll, 2001; Ulrich et al., 2003).

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### Use or Nonuse of Physical or Chemical Restraints

- Administering life-prolonging aggressive therapies.
- Discontinuing or initiating treatments such as dialysis, particularly with regard to terminally ill patients.
- Over- or undertreating patients.
- Deciding what is right and what should be done.
- Overriding patient care needs by business decisions.
- Having to follow various medical or institutional practices.
- Dealing with payment issues.

<table>
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<tr>
<th>Justice</th>
<th>Professional/personal integrity</th>
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<tr>
<td>Use or nonuse of physical or chemical restraints.</td>
<td>—Communication.</td>
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<td></td>
<td>—Recognizing own values and norms that influence actions.</td>
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<td>—Compromising personal values and ethics.</td>
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<td></td>
<td>—Concern over becoming agents for the health plan rather than patient advocates.</td>
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<td></td>
<td>—Providing care with possible risks to nurses’ health.</td>
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<td>—Providing care with risk to self.</td>
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<td>—Nurse-physician relationships.</td>
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<td>—Child/parent/practitioner relationship.</td>
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**Note:** Table is not exhaustive (Butz et al., 1998; Ferrell & Rivera, 1995; Killen et al., 1996; Redman & Fry, 1996, 1998a, 1998b, 2000, 2003; Redman et al., 1997; Severinsson & Hummelvoll, 2001; Ulrich et al., 2003).

### WHY IS ADDRESSING ETHICAL PROBLEMS IN NURSING IMPORTANT?

As trained professionals, nurses are moral agents caring for the intimate needs of the ill and infirmed, acting on their professional knowledge for the betterment of the patient. Moral agency has been conceptualized as an “action based upon self-embodied principles and knowledge to facilitate a perceived positive outcome for the patient, family, or society” (Raines, 1994, p. 7). But technological innovations, along with an aging society, changing cultural demography, and fragility within the health care system, have created complex ethical challenges for nurses and threaten their agency. Questions continually arise regarding the appropriate and ethical use of technology, the fair and judicial use of limited resources, and equality of health care. Today, “it is not enough to recognize that something is morally wrong; to truly be good moral agents, we also must know how to confront wrongful behavior” (Cooper, 2004, p. 82).

It seems plausible to question if nurses are considered good moral agents if they perceive there are some ethical problems they can do nothing about, report powerlessness, fail to confront ethical conflicts in patient care for fear of reprisal, are morally distressed (i.e., the agent knows the morally right course of action but is inhibited from carrying out the action because of institutional or other identified constraints), and if 25% or more want to leave their positions (Danis et al., 2008; Hamric &

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Blackhall, 2007; Hamric, Davis, & Childress, 2006; Jameton, 1984; Ulrich et al., 2007). If nurses are so unsatisfied and distressed, how can they act to facilitate positive outcomes for patients—particularly when they face a history of subordination? Despite these problems, one of nurses’ primary roles is patient advocacy. But if they perceive such powerlessness, how do they advocate for appropriate patient care? There seems to be a disconnect between the manner in which nurses accept responsibility in their professional roles and the manner in which they perceive their effectiveness, particularly when it comes to difficult ethical decisions.

Among these other problems that nurses perceive, about one out of four nurses report physical symptoms associated with ethical problems (e.g., headaches, stomach aches, tension in neck or shoulders) and/or report burnout and emotional exhaustion, and many simply feel disrespected within health care settings (Laschinger, 2004; Ulrich et al., 2007). Limited perceived organizational support for ethical issues in nursing practice raises concerns about the ability to openly voice dissent and challenge assumptions/practices related to ethical decision-making in patient care. Indeed, several authors posit a relationship between health outcomes of hospital employees including nurses (i.e., absences due to sickness) and perceived levels of organizational justice (Elovainio, Kivimaki, & Vahtera, 2002).

Addressing ethical challenges in nursing practice is imperative if we want to retain qualified professionals, maintain the quality and personal nature of the nurse-patient relationship, and improve the health and well-being of patients, families, and the providers who care for them. Unfortunately, merely 23% of nurses have received ethics education, and Grady et al. (2008) report a significant relationship between ethics education and nurses’ ability to take moral action. Ethics education is necessary but not sufficient to resolve all of the ethical problems that nurses experience; it can, however, assist providers to articulate and advocate for their moral positions, potentially increasing their negotiating power within health care institutions. As Lützén, Cronqvist, Magnusson, and Anderson (2003) commented: “Leaving nursing may be the last resort for some and one way of avoiding the negative consequences of moral stress, and subsequent ill health, but this does not solve any problems for the common good of health care” (p. 320). In a similar way, for those who choose to stay in their positions, ethical numbing or adaptability may occur where a go along to get along mentality is perceived as necessary when personal values conflict with institutional constraints (Mohr & Mahon, 1996; Ulrich, 2001; Wynia, Cummings, VanGeest, & Wilson, 2000). But this too has consequences. What harm do we do ourselves and others if we remain in our positions but are morally mute (Bird, 1996)?

CONCLUSION

As nurses continue to struggle with a multitude of ethical problems in the workplace, it has become imperative that we concentrate our efforts on finding solutions to overcome these challenges. More empirical bioethics research and ethical discourse among key stakeholders will allow us to identify the best strategies that help nurses address the ethical challenges in their practice. In doing so, they can meet their most fundamental role of patient care and patient advocacy in a manner that upholds their moral integrity. It is no longer acceptable to avoid, dismiss, or diminish the ethical problems that nurses encounter. Throughout the history of nursing, ethics has served as a cornerstone of professional conduct, beneficent care, and societal good. The ethical problems then and now are real and are dramatically affecting nurses and patient care. If nursing is to continue in its healing, caring, and advocacy traditions, we must take nursing ethics seriously as a discipline in order to create necessary change.

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References


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